Office of the Healthcare Advocate
STATE OF CONNECTICUT

Testimony of Victoria Veltri
State Healthcare Advocate
Before the Public Health Committee
In support of HB 6588
March 20, 2013

Good morning, Representative Johnson, Senator Gerratana, Senator Welch, Representative Srinivasan, and members of the Public Health Committee. For the record, I am Vicki Veltri, State Healthcare Advocate with the Office Healthcare Advocate ("OHA"). OHA is an independent state agency with a three-fold mission: assuring managed care consumers have access to medically necessary healthcare; educating consumers about their rights and responsibilities under health insurance plans; and, informing you of problems consumers are facing in accessing care and proposing solutions to those problems.

Thank you for the opportunity to comment on HB 6588, An Act Concerning The Expiration Of Certain Healthcare Provider Contracts. The requirement that consumers receive notice of impending contract termination between a hospital organization and an insurer significantly enhances consumer protections by providing timely notice that treating their treating providers may soon no longer be in the insurer's network. Connecticut law requires that insurers notify consumers at least 30 days prior to the termination of a contract between the insurer and an in-network provider. However, nearly 60% of insured Connecticut consumers are covered under self-insurer plans which are not subject to state law. Many others have coverage that is issued in another state. This variation in notice requirements can leave consumers struggling to find alternate in-network services or potentially burdened with paying for ongoing care while they wait for an appointment with a new in-network provider. SB 6588 utilizes provider's knowledge of all consumers who will be affected by a change in the network, irrespective of where the plan is issued or under which law it is subject to, and affirms that consumers receive notice that is adequate for them to identify and receive alternate appropriate care, or initiate the continuity of care process with the insurer should no appropriate alternate be available.

The additional requirement that insurers, which I believe was the intent of section (c), renew their certification pursuant to C.G.S. 38a-472f acknowledges the reality that Connecticut is a small state and that the loss of one hospital organization from a network can materially affect the adequacy of an insurer's network. It has long been a basic premise that a managed care organization must have a network of providers sufficient to deliver the services that

consumers are paying premiums to have access to. With the increasing consolidation of provider groups and hospital organizations, consumer access to healthcare providers may be significantly impacted when one opts to terminate its contract with the insurer. OHA has assisted consumers in this untenable situation in the past, when they were stuck in the middle of a contract dispute between their insurer and their healthcare provider. Many consumers receive 60 days notice prior to the contract's termination from the insurer, but struggle to find alternate in-network providers with appropriate experience to manage their medical needs. Many more received no notice because their insurance was issued by a plan in another state that merely used the local plan's network. These out of state insurers would have no knowledge of the looming change to the local network and, even if they did, are not required to provide notice to their members. HB 6588 mitigates this situation by requiring local plans to certify that their network remains in compliance with the certification that they have received from NCQA or URAC following a potentially material change to its network, as well as its fiduciary duty to its members.

Please consider the following substitute language to reflect the intent in section (c), as well as the deletion in section (b) that improperly assigns the insurer's responsibility for notifying consumers of options for continuing to receive service to the hospitals.

(b) Not later than ninety days before the expiration of such contract, the hospital or physician-hospital organization shall provide written notice to all current patients that may be affected by the expiration of such contract that includes: (1) The expiration date of such contract; (2) a statement that the hospital or physician-hospital organization may not be in-network after expiration of the contract; (3) [information concerning the available procedures for a patient to continue existing coverage or secure alternative coverage for future treatment; (4)] contact information for the appropriate person or department of the hospital or the physician-hospital organization and the insurer, health care center or medical service corporation; and ([5]4) contact information for the Office of the Healthcare Advocate.

(c) Not later than thirty days before the expiration of a contract between a hospital or a physician-hospital organization and an insurer, health care center or medical service corporation, the [hospital or physician-hospital organization] <u>insurer</u> shall: (1) Certify [Obtain a certification or accreditation from the National Committee for Quality Assurance or URAC] that the network of providers [is likely to] <u>shall</u> remain consistent with the National Committee for Quality Assurance's network adequacy requirements or URAC's provider network access and availability standards after expiration of such contract; and (2) submit such certification [or accreditation] to the Insurance Commissioner.

There is no reason that consumers should be unduly affected by a failure of the insurer and hospital to reach an equitable agreement. HB 6588 merely ensures that all parties have prior knowledge of the impact that contract termination will have. Thank you for providing me the opportunity to deliver OHA's testimony today. If you have any questions concerning my testimony, please feel free to contact me at victoria.veltri@ct.gov.